Supreme Court, U.S.
FILED
DEC 17 1999
CLERK

No. 98-1836

In the Supreme Court of the United States

UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC., PETITIONER

v.

PENNSYLVANIA HOSPITAL INSURANCE CO., ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF PENNSYLVANIA

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTION PRESENTED

Whether Section 514(a) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1144(a), preempts state law claims arising from a health maintenance organization's negligence in denying a claim for benefits under an ERISA-governed health plan.

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BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

This brief is submitted in response to the Court's invitation to the Solicitor General to express the views of the United States.

STATEMENT

1. The original plaintiffs in this case, Basile and Theodora Pappas, were subscribers to a health maintenance organization (HMO) operated by petitioner United States Healthcare Systems of Pennsylvania, Inc., a subsidiary of Aetna, Inc. Pet. App. 20a; Pet. ii. The Pappases received HMO coverage through an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1002(1), sponsored by Mrs. Pappas' employer, The Charming Shoppes. Pet. App. 35a-36a. Petitioner's HMO provided most medical care by con-

tracting with participating providers. Pet. 2. In a medical emergency, however, the HMO covered treatment by non-participating providers. Super. Ct. Reproduced R. ("R.") 156a ("Emergency care is covered anytime, anywhere."); *id.* at 158a ("In an emergency, you should contact your primary care physician for help. When a delay would be detrimental to your health, seek the nearest medical attention. Always call the toll-free number on the back of your membership card * * * within 24 hours after receiving emergency care.").

On May 20, 1991, Mr. Pappas went to his primary care doctor, Dr. David Asbel, complaining of neck and shoulder pain, and was treated with an injection of steroids. Pet. App. 35a. The next morning, after his condition had worsened, Pappas was transported by ambulance to Haverford Community Hospital (Haverford), where he was admitted at 11:00 a.m. By that time, he was paralyzed from the chest down. The emergency room physician, Dr. Stephen Dickter, in consultation with a neurologist and a neurosurgeon, diagnosed a probable epidural abscess pressing on Pappas' spine, a neurological emergency requiring immediate surgery. By 12:30 p.m., Dr. Dickter had made arrangements to transfer Pappas to Thomas Jefferson University Hospital (Jefferson), which had a spinal cord trauma unit able to commit to his immediate admission. *Id.* at 2a-3a, 21a, 36a.

At 12:40 p.m/, the ambulance service that was to transport Pappas to Jefferson told Dr. Dickter that petitioner would not authorize Pappas's transfer to Jefferson. At 12:50 p.m., Dr. Dickter called petitioner to request authorization, making clear that the situation was a neurological emergency. Pet. App. 3a, 21a, 36a. At 1:05, a representative of petitioner told Dr. Dickter that petitioner would not authorize treatment at Jefferson because it was not approved by petitioner, but that it would cover treatment at any of three other participating university hospitals. *Id.* at 21a, 36a. Dr.

Dickter then initiated a series of telephone calls to arrange for Pappas's admission at one of the three approved hospitals, resulting in further delays before he underwent surgery that evening. *Id.* at 3a, 21a-22a, 36a-37a. Pappas now suffers from permanent quadriplegia caused by compression of his spine by the abscess. *Id.* at 3a, 22a, 37a, 51a-52a.

2. The Pappases brought a common law tort action in state court against Dr. Asbel and Haverford, alleging that Dr. Asbel had committed medical malpractice and that Haverford was negligent in causing an inordinate delay in transferring Pappas. Pet. App. 3a, 22a. Haverford filed a third-party complaint against petitioner, joining it as a defendant for refusing to authorize Pappas's transfer to Jefferson and adopting (for purposes of that third-party complaint) the negligence claims made against Haverford in the original complaint. *Id.* at 3a, 22a, 37a, 41a, 60a.[1]

The Pennsylvania trial court granted summary judgment to petitioner. Pet. App. 34a-44a. It held that ERISA preempts Haverford's third-party complaint because "[a]ll of [its] allegations fall within the rubric of administration of an employee benefit plan." *Id.* at 41a. Thus, it considered this case analogous to cases preempting state claims for "failure to pay a benefit claim or preapprove a procedure," which have an "obvious connection or reference to a benefit plan," and different from cases holding that "ERISA does not preempt state law claims against an HMO sued on a theory of vicarious liability generally or ostensible agency specifically" based on the negligence of others in furnishing care. *Id.* at 42a-43a.

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[1] Dr. Asbel also filed a cross-claim against petitioner seeking contribution and indemnity, Pet. App. 3a-4a, 22a, 37a, which apparently was not pursued and is not before this Court. See Pet. 5-6; Pet. App. 22a n.2, 38a, 46a.

Plaintiffs' claims against Dr. Asbel and Haverford were later settled. Pet. App. 4a n.2, 22a n.2, 45a-46a. The trial court entered an order approving the settlement, substituting respondents Pennsylvania Hospital Insurance Company and the Commonwealth of Pennsylvania Medical Professional Liability Catastrophe Loss Fund for Haverford as the real parties in interest, and declaring final its earlier order granting summary judgment to petitioner. *Id.* at 46a. Respondents appealed.

3. The Pennsylvania Superior Court reversed and remanded. Pet. App. 18a-33a. Characterizing the negligence claim here as "an indirect source of merely economic influence on administrative decisions," *id.* at 28a (citation omitted), it reasoned that "ERISA is in no way implicated by the claim that [petitioner] negligently caused Mr. Pappas' injuries by its delay in authorizing his transfer." *Id.* at 31a. Despite its observation that "the argument has never been advanced that the decision to withhold approval for transfer to Jefferson was at all related to medical considerations," *id.* at 27a, the Superior Court concluded that the claims are directly related to "general health care regulation" rather than plan administration, and thus are presumptively left to the States under *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Insurance Co.*, 514 U.S. 645 (1995). Pet. App. 26a-28a.[2]

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[2] The court also noted that, "if the original complaint had claimed that [petitioner] was vicariously liable because of the negligence of its contracting agents, Dr. Asbel and Haverford, in securing Mr. Pappas' transfer, there would be no question" that the claim would withstand preemption. Pet. App. 31a-32a. In fact, the record is unclear on whether either Dr. Asbel or Haverford had a contractual relationship with petitioner as a participating provider in its HMO network. Since the HMO is structured to provide services through primary care physicians, and Dr. Asbel, an osteopath, performed that role for Mr. Pappas, we assume that he was a participating provider. See Pet. App. 3a, 20a; R. 158a. Dr. Dickter, who had worked full-time in Haverford's emergency room for ten months at

4. The Pennsylvania Supreme Court affirmed. Pet. App. 1a-13a. The court held broadly that "negligence claims against a health maintenance organization do not 'relate to' an ERISA plan." *Id.* at 11a. It reached that conclusion based on the view that this Court "noticeably changed tack" in its *Travelers* decision, *id.* at 7a, interpreting ERISA's pre-emption provision less expansively than in earlier cases. *Id.* at 9a. *Travelers*, the court said, established that "Congress did not intend to preempt state laws which govern the provision of safe medical care." *Id.* at 11a. Since "[c]laims that an HMO was negligent when it provided contractually-guaranteed medical benefits in such a dilatory fashion that the patient was injured indisputably are intertwined with the provision of safe medical care," the court concluded that the claims in this case are not preempted. *Id.* at 11a-12a. The court also reasoned that state negligence laws of general applicability have only a "tenuous, remote, or peripheral connection with [ERISA] covered plans," and have only an incidental impact on the fees charged by HMOs to ERISA plans. *Id.* at 12a (citing *Travelers*, 514 U.S. at 661, and *De Buono* v. *NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814-816 (1997)).[3]

Justice Nigro concurred separately. Pet. App. 14a-16a. In his view, ERISA does not preempt the third-party claims because petitioner's actions "constituted, in effect, an individual medical decision or judgment as opposed to a decision affecting the administration of an employee benefit plan." *Id.* at 15a. Relying on *Dukes* v. *U.S. Healthcare, Inc.*, 57

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the time of these events, testified that he had never previously called petitioner for any purpose. R. 60a, 67a. This suggests, if anything, that Haverford was not a participating provider.

[3] The court disagreed, however, with the Superior Court's reasoning that the state-law claims at issue here are not preempted because "Congress, when crafting ERISA, was ignorant of the cost containment procedures utilized by HMOs." Pet. App. 12a n.6.

F.3d 350 (3d Cir.), cert. denied, 516 U.S. 1009 (1995), he concluded that this case involves claims about the quality of health care benefits actually received, which are not preempted by ERISA, rather than claims that the quantum of benefits promised was not provided, a dispute that ERISA does control. Pet. App. 15a-16a.

DISCUSSION

The Pennsylvania Supreme Court held flatly that "negligence claims against a health maintenance organization do not 'relate to' an ERISA plan." Pet. App. 11a. In our view, that holding is both overbroad and incorrect as applied to this case. In many circumstances, including this case, the blanket non-preemption rule announced by the Pennsylvania Supreme Court conflicts with the core holding of *Pilot Life Insurance Co.* v. *Dedeaux*, 481 U.S. 41, 48 (1987), that ERISA preempts state common-law causes of action for improper processing of a claim for benefits under an employee benefit plan. The Pennsylvania Supreme Court's decision also conflicts with a number of federal court of appeals decisions holding that ERISA preempts state-law claims challenging decisions by HMOs and other plan administrators to deny or delay authorization for particular medical treatments or treatment at particular hospitals. Finally, questions regarding the scope of ERISA preemption of negligence claims against HMOs are currently of great nationwide importance. This Court's disposition of *Pegram* v. *Herdrich*, No. 98-1949 (to be argued Feb. 23, 2000), may have relevance to this case, and we therefore suggest that the Court hold the petition in this case pending its decision in *Pegram*. But both the conflict between the Pennsylvania Supreme Court and several courts of appeals, and the importance of the question presented here, suggest that, if

Pegram does not clearly resolve this case, plenary review would be warranted.[4]

1. Based on the limited but undisputed facts of record in this case, it appears that petitioner denied Mr. Pappas a benefit he was entitled to receive under the terms of his plan —emergency care at a hospital outside the HMO network— and that respondents seek to hold petitioner liable for its negligence in making that erroneous benefit determination. When viewed in that light, respondents' claims are preempted by ERISA because they relate to plan administration and would provide an independent enforcement mechanism as an alternative to ERISA's limited remedies. As a result, the Pennsylvania Supreme Court decision is both incorrect in this case and overbroad as a general matter under existing law.[5]

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[4] Respondents argue (Br. in Opp. 4-5) that this Court lacks jurisdiction under 28 U.S.C. 1257(a) because the decision of the Pennsylvania Supreme Court is not a final judgment. We agree with petitioner (Reply Br. 1-6) that this case meets the four requirements for immediate review under *Cox Broadcasting Corp.* v. *Cohn*, 420 U.S. 469, 482-483 (1975): (1) the federal question, concerning ERISA preemption, has been finally decided; (2) petitioner might prevail on remand on nonfederal grounds, making review of the federal issue unnecessary; (3) reversal of the state court judgment on preemption grounds would preclude further litigation; and (4) denying immediate review might seriously erode federal policy regarding the scope of ERISA preemption of tort claims against HMOs. This Court has previously granted certiorari to review an ERISA preemption case in a similar posture without commenting on any jurisdictional issue. See *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 136-137 (1990) (reviewing case in which Texas Supreme Court, holding that state wrongful discharge claims were not preempted, had reversed and remanded for trial).

[5] The Department of Labor has supported proposed amendments to ERISA to provide more effective remedies for improper benefit determinations, either by narrowing ERISA preemption or strengthening ERISA remedies or both. See *ERISA Preemption: Remedies for Denied or Delayed Claims: Hearing Before a Subcomm. of the Senate Comm. on Appropriations*, 105th Cong., 2d Sess. 5-14 (1998) (testimony of Assistant

As we explain in our recent amicus brief in *Pegram* v. *Herdrich*, No. 98-1949 (filed November 19, 1999), an HMO can perform various functions in relation to an employee welfare benefit plan. *In re U.S. Healthcare, Inc.*, 193 F.3d 151, 162 (3d Cir. 1999); *Dukes* v. *U.S. Healthcare, Inc.*, 57 F.3d 350, 361 (3d Cir.), cert. denied, 516 U.S. 1009 (1995). First, by its very nature, an HMO serves as a medical-service provider to the plan, contracting for or directly providing medical care to the plan's participants and beneficiaries. *In re U.S. Healthcare*, 193 F.3d at 162. Second, it may serve as a plan administrator, performing administrative duties such as determining eligibility for benefits, calculating and disbursing benefits, monitoring available funds, and keeping records. *Ibid.*; see also *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 9 (1987).[6] Those roles can and should be distinguished

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Secretary Olena Berg) [hereinafter Berg Testimony]; see also H.R. 2990, 106th Cong., 1st Sess. § 1302 (1999) (provision in House-passed version of Patients' Bill of Rights amending Section 514 of ERISA, 29 U.S.C. 1144, to save from preemption certain state personal injury claims involving group health plans). The Department's position is based on the belief that participants and beneficiaries of ERISA-covered health plans currently have inadequate remedies for the negligence of plan administrators in making benefit determinations. ERISA itself does not provide compensatory damages for the improper processing of benefit claims. *Mertens* v. *Hewitt Assocs.*, 508 U.S. 248 (1993); *Massachusetts Mut. Life Ins. Co.* v. *Russell*, 473 U.S. 134 (1985). At the same time, under *Pilot Life*, ERISA appears to preempt most, if not all, state-law causes of action that could provide such relief. Cf. *UNUM Life Ins. Co. of Am.* v. *Ward*, 119 S. Ct. 1380, 1390-1391 n.7 (1999).

[6] An HMO also acts as an insurer to the extent that it bears risk. See *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205, 227 n.34 (1979) (noting that "certain aspects" of advance-payment medical-benefits plans may be the "business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. 1012). See also *Washington Physicians' Serv. Ass'n* v. *Gregoire*, 147 F.3d 1039, 1045-1046 (9th Cir. 1998) (an HMO "provides medical services directly" and also is "in the business of insurance"), cert. denied, 119 S. Ct. 1033 (1999); *Anderson* v. *Humana, Inc.*, 24 F.3d 889, 892 (7th

for purposes of ERISA preemption analysis, but the Pennsylvania Supreme Court failed to do so.

To understand those roles, it is helpful to begin with ERISA's definition of a plan—particularly since both Pennsylvania appellate courts incorrectly assumed that petitioner's HMO is identical to the employee benefit plan sponsored by Mrs. Pappas's employer. Pet. App. 4a n.1, 23a n.3. ERISA defines an "employee welfare benefit plan" as "any plan, fund, or program * * * established or maintained by an employer * * * for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise * * * medical, surgical, or hospital care or benefits" or other benefits. 29 U.S.C. 1002(1). Based on that definition, the essentials of a plan have been interpreted to be the existence of "intended benefits, a class of beneficiaries, [a] source of financing, and procedures for receiving benefits." *Donovan* v. *Dillingham*, 688 F.2d 1367, 1373 (11th Cir. 1982); accord *Grimo* v. *Blue Cross/Blue Shield*, 34 F.3d 148, 151 (2d Cir. 1994); *Kenney* v. *Roland Parson Contracting Corp.*, 28 F.3d 1254, 1257-1258 (D.C. Cir. 1994) (collecting cases).

The ERISA plan in this case was the arrangement by which The Charming Shoppes, Mrs. Pappas' employer, undertook to provide medical benefits to eligible employees and their families, in this instance by purchasing memberships in petitioner's HMO. The intended benefit was coverage for the specific kinds of medical care specified in the Group Master Contract between petitioner and The Charming Shoppes, care that is generally provided (except in emergencies) by doctors and hospitals under contract with petitioner. R. 158a; see *Danca* v. *Private Health Care Sys., Inc.*, 185 F.3d 1, 6 n.6 (1st Cir. 1999) (explaining that the benefits under an ERISA health plan are "the monetary payments

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Cir. 1994). But see *Texas Pharmacy Ass'n* v. *Prudential Ins. Co.*, 105 F.3d 1035, 1038-1039 (5th Cir.), cert. denied, 522 U.S. 820 (1997).

for medical services, not the services themselves"). The intended beneficiaries were The Charming Shoppes' employees and their dependents enrolled in the HMO. The source of funding was The Charming Shoppes, which paid premiums to petitioner. Pet. 2; Pet. App. 35a-36a. And the procedure to apply for and collect benefits under the HMO is outlined in the Member Handbook and Group Master Contract. Under that procedure, petitioner decides whether to authorize or reimburse treatment. R. 158a; Pet. 17. Petitioner itself, however, is not an ERISA plan; rather, it is a service provider to the plan and to its participants and beneficiaries.

As was true here, HMOs can perform at least two different roles in their relationship with members who are enrolled under ERISA plans, and the correct identification of the role being performed can have profound consequences under ERISA. When an HMO acts as a medical service provider, a number of courts have held—and we agree—that the HMO is subject to suit under state law for negligence in performing its medical duties. *In re U.S. Healthcare, supra*; *Rice* v. *Panchal*, 65 F.3d 637 (7th Cir. 1995); *Pacificare of Okla., Inc.* v. *Burrage*, 59 F.3d 151 (10th Cir. 1995); *Dukes* v. *U.S. HealthCare, Inc.*, 57 F.3d 350 (3d Cir.), cert. denied, 516 U.S. 1009 (1995); *Lupo* v. *Human Affairs Int'l, Inc.*, 28 F.3d 269 (2d Cir. 1994). In those cases, the nonpreempted claims were generally either vicarious liability claims against an HMO for medical malpractice by its agents, or direct claims against the HMO for its negligence in selection and supervision of those agents. See, *e.g.*, *Dukes*, 57 F.3d at 352-353.

On the other hand, when an HMO makes benefit determinations in its role as a plan administrator, most courts have held—and we agree—that ERISA preempts any state-law challenges to those decisions. See, *e.g.*, *Parrino* v. *FHP, Inc.*, 146 F.3d 699 (9th Cir.) (HMO denial of particular cancer

treatment), cert. denied, 119 S. Ct. 510 (1998); *Turner* v. *Fallon Community Health Plan, Inc.*, 127 F.3d 196 (1st Cir. 1997) (same), cert. denied, 523 U.S. 1072 (1998); *Cannon* v. *Group Health Serv. of Okla., Inc.*, 77 F.3d 1270 (10th Cir.) (HMO delay in authorizing particular cancer treatment), cert. denied, 519 U.S. 816 (1996); *Kuhl* v. *Lincoln Nat'l Health Plan of Kansas City, Inc.*, 999 F.2d 298 (8th Cir. 1993) (HMO delay in authorizing surgery at non-network hospital), cert. denied, 510 U.S. 1045 (1994).

The Labor Department's ERISA claims regulations (both current and proposed) also recognize that HMOs, like insurance companies and other organizations outside the plan itself, may be responsible for making claim determinations under an employee benefit plan. See 29 C.F.R. 2560.503-1(c), (g)(2) and (j); see also 63 Fed. Reg. 48,408 (1998) (proposed amended claims regulation defining an "adverse benefit determination" to include benefit denials "resulting from the application of any utilization review directed at cost containment"); see also *id.* at 48,406 (addressing claims procedures of plans in which benefits are provided by an HMO or similar entity). As both the case law and the regulations show, such benefit determinations will often involve a significant component of medical judgment, and may have tragic medical consequences. But, so long as the judgment is an adjunct to a plan coverage decision, rather than a judgment made primarily in the course of diagnosis or treatment, it is a "benefit determination nonetheless." *Corcoran* v. *United HealthCare, Inc.*, 965 F.2d 1321, 1332 (5th Cir.), cert. denied, 506 U.S. 1033 (1992).[7] And benefit determinations can be chal-

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[7] If, however, the HMO makes the treating physician's medical judgment in rendering treatment decisions the sole basis for coverage determinations under an ERISA plan, ERISA would not preempt state malpractice claims against the treating physician or state vicarious liability claims against the HMO for those treatment decisions (as opposed to the benefit decisions).

lenged only under ERISA, not under state law, as this Court held in *Pilot Life* (discussed at pp. 14-16, *infra*).

The distinction between plan administration and medical treatment may not always be easy to apply in practice. In this case, however, the Pennsylvania Supreme Court did not suggest that petitioner acted other than in its role as plan administrator, or, indeed, that petitioner exercised any medical judgment at all. Rather, the undisputed facts indicate that petitioner, responding to an inquiry from a physician on behalf of a patient, made a benefit determination. Although that determination conflicted with the terms of the plan regarding emergency care and may have contributed to an avoidable personal tragedy for Mr. Pappas and his wife, t was a "benefit determination nonetheless." *Corcoran*, 965 F.2d at 1332. In these circumstances, it is clear that any state-law action the Pappases themselves could have brought against petitioner for negligent claims processing or misinterpretation of plan terms would have been preempted.[8] It is equally clear that the Pappases could have (and did) bring a state negligence action against Dr. Asbel and Haverford that is entirely outside ERISA's preemptive reach.

The preemption analysis is somewhat complicated because the claim before the Court was brought by Haverford, a

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[8] ERISA provides a participant or beneficiary with causes of action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan," 29 U.S.C. 1132(a)(1)(B), and "to enjoin any act or practice which violates any provision of [ERISA] or the terms of the plan, or * * * to obtain other appropriate equitable relief," 29 U.S.C. 1132(a)(3). By the time the Pappases could bring suit here, however, there was no further plan benefit due to them (appropriate treatment, albeit critically delayed, had been provided and paid for), and there was no injunctive or other equitable relief that could provide an appropriate or meaningful remedy. Cf. *Mertens* v. *Hewitt Assocs.*, 508 U.S. 248, 255-258 (1993) (only traditional equitable relief available under ERISA).

medical service provider, rather than directly by the Pappases. Normally, a medical service provider has standing to bring an ERISA claim only if it is an assignee of a participant or beneficiary. See 29 U.S.C. 1132(a); *Cagle* v. *Bruner*, 112 F.3d 1510, 1515 (11th Cir. 1997) (collecting cases). When a service provider brings such a derivative claim, it is limited to ERISA remedies, and ERISA preempts any remedies under state law. See, *e.g.*, *Memorial Hosp. Sys.* v. *Northbrook Life Ins. Co.*, 904 F.2d 236, 250 (5th Cir. 1990). On the other hand, a number of courts have held that a service provider can sometimes bring an independent state-law action against a plan administrator for negligent misrepresentation without running afoul of ERISA preemption. *In Home Health, Inc.* v. *Prudential Ins. Co. of Am.*, 101 F.3d 600, 604 (8th Cir. 1996) (collecting cases). In those cases, a service provider has typically contacted a plan administrator to ask whether an individual is covered by the plan, been assured that coverage existed, provided services in reliance on that assurance, and later been refused payment on the ground that coverage did not exist under the plan. See, *e.g.*, *id.* at 602; *Lordmann Enters., Inc.* v. *Equicor, Inc.*, 32 F.3d 1529, 1530-1531 (11th Cir. 1994), cert. denied, 516 U.S. 930 (1995); *Memorial Hosp. Sys.*, 904 F.2d at 238.

Although neither line of service-provider cases addresses the precise scenario presented here, their underlying principles support the conclusion that respondents' claims are preempted. Haverford's third-party complaint alleged that petitioner was liable for Haverford's delay in transferring Mr. Pappas to a suitable hospital. Pet. App. 60a. It did not allege that petitioner misled it or reneged on any promise. The only specific allegation against petitioner is that petitioner refused to authorize coverage of treatment at Jefferson, when asked to do so by Haverford on behalf of Mr. Pappas. Under these circumstances, the complaint necessarily alleges that petitioner made a benefit determination un-

der the plan, which can be challenged only under ERISA. Respondents' common-law negligence claim is therefore preempted.[9]

2. In *Pilot Life*, the Court held that ERISA preempts state common law causes of action "based on alleged improper processing of a claim for benefits under an employee benefit plan." 481 U.S. at 48. It reached that conclusion for three reasons: (1) there was "no dispute that the common law causes of action asserted in Dedeaux's complaint 'relate to' an employee benefit plan" within the meaning of ERISA's express preemption provision, Section 514(a), 29 U.S.C. 1144(a), 481 U.S. at 47; (2) the state- law claims were not saved from preemption by the insurance savings clause in Section 514(b)(2)(A) of ERISA, 29 U.S.C. 1144(b)(2)(A), 481 U.S. at 48-51; and (3) the civil enforcement provisions of Section 502(a) of ERISA, 29 U.S.C. 1132(a), are "the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits." 481 U.S. at 52. The Pennsylvania Supreme Court's decision in this case conflicts with the first and third rationales for the *Pilot Life* holding.[10]

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[9] It is possible that other state-law causes of action could have been alleged in this case that would not be preempted. For example, if Dr. Asbel was a network provider, the Pappases could have alleged that petitioner was vicariously liable for his malpractice or directly negligent in selecting him as a provider. See cases cited at page 10, *supra*. But no such claims were made.

[10] The second rationale for the *Pilot Life* holding is not at issue in this case. As previously noted, p. 8 n.6, *supra*, the Secretary has argued, and several courts have held, that HMOs can be insurers for purposes of the insurance savings clause to the extent they bear insurance risks. There is no contention, however, that respondents' claims against petitioner are based on a state insurance law. Rather, like the claim in *Pilot Life*, they are based on generally applicable tort law. Thus, unlike *UNUM Life Insurance Co. of America* v. *Ward*, 119 S. Ct. 1380, 1390-1391 n.7 (1999), this case does not involve ERISA's insurance savings clause or its construction

Pilot Life involved a claim for long-term disability benefits under an ERISA plan administered by an insurance company, which bore the responsibility for making benefit determinations; the plaintiff was a plan participant whose benefits the insurer had terminated and reinstated several times. 481 U.S. at 43. The Court, however, did not focus on either the type of benefits or the reasons for their termination and reinstatement. Applying *Pilot Life* in this case, the benefit at issue was coverage or payment for emergency medical treatment at a hospital outside the HMO network of participating providers. Coverage was denied before treatment was provided, rather than after, even though preauthorization was not required in an emergency, and the denial was for reasons that contradicted the plain language of petitioner's own brochure describing the covered benefits. Nevertheless, as discussed at pages 12-13, *supra*, the cause of action here, like the one in *Pilot Life*, in essence is "based on alleged improper processing of a claim for benefits under an employee benefit plan," which this Court held is expressly preempted by Section 514(a) of ERISA. 481 U.S. at 48.

Pilot Life also relied on a theory of field preemption, holding that "Congress clearly expressed an intent that the civil enforcement provisions of ERISA § 502(a) be the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits, and that varying state causes of action for claims within the scope of § 502(a) would pose an obstacle to the purposes and objectives of Congress." 481 U.S. at 52. While this Court has never delineated the boundaries of that preempted field in the context of health care benefits, it seems clear that they overlap with the boundaries of the field that the Pennsylvania court declared nonpreempted—that is, all negligence claims against HMOs. In addition, we

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in *Pilot Life*. Nor does this case involve ERISA's deemer clause, 29 U.S.C. 1144(b)(2)(B).

believe that *Pilot Life* field preemption applies to this case because respondents' claims—unlike some service-provider claims against plans—essentially challenge petitioner's denial of benefits under the plan.[11]

The Pennsylvania Supreme Court disregarded *Pilot Life* because it believed that this Court had limited that precedent's expansive interpretation of the "relate[s] to" clause in subsequent decisions such as *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645 (1995), and *De Buono* v. *NYSA-ILA Medical & Clinical Services Fund*, 520 U.S. 806 (1997). Pet. App. 6a-13a. But while *Travelers* and *De Buono* both involved state-imposed economic burdens on the provision of health care and emphasized that health care regulation is traditionally left to the States, they did not involve state causes of action for benefits against ERISA plans. As a result, neither case can reasonably be read to limit *Pilot Life*'s holding that such causes of action "relate to" plans or that "ERISA's civil enforcement remedies were intended to be exclusive" with respect to such causes of action. 481 U.S. at 54. On the contrary, *Travelers* reaffirms the Court's earlier holdings that ERISA preempts "state laws that mandate[] employee benefit structures or their administration," as well as "state laws providing alternative enforcement mechanisms" to those contained in ERISA. 514 U.S. at 658.[12]

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[11] We note that the Court indicated in *Pilot Life* that the field preemption effect of Section 502 extended so far as to preempt even state insurance laws that would otherwise be saved by ERISA's insurance savings clause. See 481 U.S. at 52-57. We have argued that that conclusion may be subject to doubt. See U.S. Amicus Br. 20-25, *UNUM Life Ins. Co. of Am.* v. *Ward*, 119 S. Ct. 1380 (1999). See also *UNUM*, 119 S. Ct. at 1390 n.7. That issue is not presented here, however, since the state-law cause of action at issue here is not one arising under a law that would be saved by ERISA's insurance savings clause. See note 10, *supra*.

[12] Because we do not understand the Pennsylvania Supreme Court to have "impose[d] a substantive coverage requirement on ERISA-governed

3. The Pennsylvania Supreme Court's decision also conflicts with a long list of federal court of appeals decisions, both before and after *Travelers*, holding that ERISA preempts state-law challenges to decisions by HMOs, insurers, utilization review organizations, and other plan administrators to deny or delay authorization for particular medical treatments or treatment at particular hospitals. See, *e.g.*, *Hull* v. *Fallon*, 188 F.3d 939 (8th Cir. 1999) (refusal to authorize particular diagnostic test); *Danca* v. *Private Health Care Sys., Inc.*, *supra* (refusal to authorize treatment at a particular hospital); *Bast* v. *Prudential Ins. Co. of Am.*, 150 F.3d 1003 (9th Cir. 1998) (delay in authorizing particular cancer treatment), cert. denied, 120 S. Ct. 170 (1999); *Jass* v. *Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996) (refusal to authorize physical therapy after knee surgery); *Cannon* v. *Group Health Serv. of Okla., Inc.*, *supra* (delay in authorizing particular cancer treatment); *Tolton* v. *American Biodyne, Inc.*, 48 F.3d 937 (6th Cir. 1995) (refusal to authorize psychiatric benefits); *Kuhl* v. *Lincoln Nat'l Health Plan of Kansas City, Inc.*, *supra* (delay in authorizing surgery at non-network hospital); *Corcoran* v. *United HealthCare, Inc.*, *supra* (refusal to authorize hospitalization during high-risk pregnancy). Two of those cases, *Danca* and *Kuhl*, specifically involved decisions by a utilization review or health maintenance organization to deny preauthorization for treatment at a particular hospital recommended by the patient's treating physician.

In each of those cases from seven different circuits, the courts treated a decision to deny pre-authorization for medical treatment as a type of benefit determination for which a

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health plans," Pet. 8, as distinct from having subjected petitioner to suit for an erroneous or negligently delayed coverage determination, we do not agree with petitioner that the decision below conflicts with *Metropolitan Life Insurance Co.* v. *Massachusetts*, 471 U.S. 724, 739 (1985), or *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85 (1983). See Pet. 8-9.

state-law claim is preempted under *Pilot Life*, and also often completely preempted under *Metropolitian Life Insurance Co.* v. *Taylor*, 481 U.S. 58 (1987), requiring removal to federal court. See, *e.g.*, *Danca*, 185 F.3d at 5-6; *Kuhl*, 999 F.2d at 302-303. Thus, the federal courts of appeals have concluded uniformly that *Pilot Life* mandates preemption of state-law negligence claims alleging improper benefit determinations by managed health care organizations acting on behalf of ERISA plans. The decision of the Pennsylvania Supreme Court is in conflict with those decisions.

4. We agree with petitioner (Pet. 19-22) that, regardless of the merits, this is an area of law of great importance. A majority of the 123 million Americans who receive health care through ERISA-regulated employee benefit plans are now subject to a managed care regime in which at least some coverage decisions are made before treatment is provided. See Berg Testimony at 14. The profusion of litigation in the lower courts as to the extent of ERISA preemption with respect to activities by HMOs is further testament to the importance of the issues presented and the regularity with which they arise. And while Congress may eventually enact new legislation in this field, it has not yet done so, and the issues under current law are significant enough to warrant review by the Court.

5. In *Pegram* v. *Herdrich*, No. 98-1949 (to be argued Feb. 23, 2000), this Court granted certiorari to review a Seventh Circuit decision holding that individuals who obtained membership in an HMO through an ERISA plan stated a claim of breach of fiduciary duty, in violation of ERISA. The plaintiff's allegations in *Pegram* concern the HMO's allegedly improper incentive payments to HMO physicians in connection with two kinds of conduct—the minimization of certain costly forms of treatment and the physicians' determination of whether certain claims fall within the scope of the medical benefits provided by the HMO.

There is a connection between the second set of allegations—the "administration" or claims-processing allegations —in *Pegram* and the allegations in this case. For example, one of the arguments advanced by the petitioners in *Pegram* (Pet. Br. 24-26)—an argument with which we disagree (see U.S. Br. 24-26)—is that the "intended benefit" in an ERISA plan that provides medical benefits through an HMO is simply membership in the HMO, not the particular medical benefits to be provided by the HMO. If, however, that contention were correct, then the conduct of the HMO in this case would not involve a claim for benefits under an ERISA plan (because it would not involve a question of membership in the HMO), and it is likely that the state-law negligence claim would therefore not be preempted (though for a reason different than that given by the Pennsylvania Supreme Court). Even if the Court rejects petitioners' contention in *Pegram* (as we believe it should), the decision in *Pegram* still could affect this case. We argue in *Pegram* (at Br. 20-23), as we argue above, see pp. 11-12, that the "administration" claims in *Pegram* are controlled by the principle that determinations regarding the benefits due under ERISA plans are governed by ERISA and its fiduciary duty standards, and we rely on this Court's precedents holding that state-law claims based on the performance of such duties are preempted precisely because they *are* governed by ERISA. If the Court adopts that view in *Pegram* and reaffirms the underlying principle, it would effectively hold or at least strongly imply that claims (such as the "administration" claims in *Pegram* and the claim in this case) regarding allegedly improper benefits determinations under ERISA plans are not subject to state law.

In short, the Court's disposition of *Pegram* could significantly illuminate the question presented in this case. For that reason, the Court may wish to hold the petition in this case pending its decision in *Pegram*. Nonetheless, the ques-

tion presented in this case (concerning preemption of state-law causes of action) is fundamentally different from the question presented in *Pegram* (concerning the scope of fiduciary duties under ERISA). For the reasons given above, the question presented here is an important one, the decision below conflicts with decisions of a number of federal courts, and the issues in this case are regularly subject to litigation around the country. Accordingly, if the decision in *Pegram* does not fully dispose of the question presented in this case, the Court should grant plenary review in this case to ensure uniform interpretation of the extent to which ERISA beneficiaries may bring state-law negligence claims against HMOs.

CONCLUSION

The petition for a writ of certiorari should be held pending this Court's decision in *Pegram* v. *Herdrich*, No. 98-1949, and then disposed of accordingly. Alternatively, the petition for a writ of certiorari should be granted.

Respectfully submitted.

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DECEMBER 1999